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ABSTRACT

The team treatment model is extremely popular in residential group care for emotionally disturbed and/or troubled children and youth; however, there is little information to verify that the model is being implemented and that desired outcomes are being obtained. This field study was designed to explore the team decision-making process through three stages of development: mobilization, deliverer implementation, and institutionalization. Data were collected by observing each of eight teams at least twice during a 2- or 3-hour team meeting, interviewing team members and administrators, and examining related documents and records. Notes were taken throughout the study and later analyzed by using a multiple coding system to identify specific classes of information. Findings were validated through use of three procedures. Results indicated that implementation had been only partially completed in each stage. Pertinent findings and recommendations for further implementation are presented. Information concerning interviews, record examination, field notes, and data analysis is appended. (Author/RH)

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IMPLEMENTATION OF A TEAM DECISION-MAKING MODEL AMONG CHILD CARE WORKERS

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Abstract

The team treatment model is extremely popular in residential group care; however, there is little information which verifies that the model is being implemented and that desired outcomes are being obtained. This field study was designed to explore the team decision-making process through three stages of development. Eight teams at four residential treatment centers were studied. The results indicated that implementation had been only partially completed in each stage. Pertinent findings and recommendations for further implementation are presented.

During the past two decades, the team approach has become extremely popular in group care agencies for emotionally disturbed and/or troubled children and youth. In a recent national survey of child and youth care workers, eighty-six percent of the respondents identified the team model as the primary treatment approach at their agencies (Krueger, Lauerman, Graham & Powell, 1983). Discussions among administrators, clinicians and practitioners have also increasingly focused on the "team" as a viable alternative for overcoming the drawbacks inherent in the more traditional centralized models of treatment delivery and decision-making (Garner, 1980; VanderVen, 1978). Indeed, it seems wherever one turns in the residential community, the team approach is being touted as the policy that has and will continue to lead to improved organizational and treatment effectiveness.

While it is obvious that the team approach has become very popular, it is also apparent that very little is known about whether or not teams actually work. A search of the group care literature reveals that there is insufficient information to indicate that predetermined goals and objectives are being reached. In other words, there are numerous articles describing the team concept and advocating its adoption, but few that provide empirical evidence indicating that the approach is actually being implemented and desired outcomes achieved.

The study presented here was designed to provide further information about the team decision-making component of the team approach. The basic premise was that since decentralized

team decision-making was the foundation for the team concept, it would be useful to determine if the process was being implemented according to agency designs. The specific objectives were to: a) describe stages or phases of decision-making implementation, b) pinpoint implementation shortcomings and successes and c) make recommendations for further implementation.

Background: Assumptions and Problems

Although the specific structure and function of team decision-making varies from program to program, there appears to be general agreement that it is a process in which members of various treatment disciplines (i.e., child care workers, teachers, social workers and consultants or clinicians) convene on a regular basis to develop individual treatment plans for an assigned group of children or youth (Garner, 1980; VanderVen, 1979). There also seems to be agreement that on effective teams, most of the decisions are made by consensus, consensus being defined as a large majority vote including agreement among members of the minority to compromise and support the final decision. When consensus can't be reached, the team abides by the decision of a predetermined authority such as a team leader or members of the administrative staff.

Enthusiasm for this approach, as opposed to the more traditional centralized model in which a clinician or single authority prescribes a plan for others to carry out, usually emanates from two assumptions about policy outcomes. First, administrators and staff members often assume that treatment effectiveness will increase if direct service staff have a format for sharing their observations

and for making recommendations and decisions related to the children or youths with whom they spend considerable time interacting. This assumption is supported by growing awareness in the field that the largest portion of treatment is embodied in daily interactions among line workers and clients and that these interactions can be improved by involving workers in designing and implementing treatment plans. (Maier, 1979; Trieschman, Whittaker & Brendtro, 1969).

The second assumption is that organizational commitment and job satisfaction among employees will increase. Support for this assumption comes from the human relations and participative management theory which has become popular in the human services field. (Hasenfeld & English, 1978; March & Simon, 1958; Maslow, 1954). In other words, staff and administrators believe that team members will be more satisfied and committed to the program if they are given the opportunity to participate in making decisions about how they will interact with the children or youths in their group.

While these assumptions do indeed provide sound reasoning for adopting the team model, it was apparent at the onset of the study that there was insufficient evidence to indicate that these assumptions had become policy outcomes. There were several reasons for lack of information about team model outcomes such as the relative newness of the model and many unanswered questions about "facts, values and basic output theory" (Berman, 1978). However, one reason more than the others was responsible for this study: it was obvious from the beginning that the team model was still subject to a series of questions about policy implementation. In other

words, there was an absence of information which indicated that the team decision-making process had actually been implemented according to the designs that were receiving so much attention in the field. Hence, without sufficient evidence to indicate that the policy has been implemented, it seemed reasonable to assume that convincing outcome studies could not be conducted (Hargrove).

Furthermore, it was also clear that at least one discipline, child care, had a history of being plagued by problems that could be interpreted as hindrances to implementation. For example, child care workers were described as having less professional status, decision-making authority, training, and work incentives than teachers or social workers. (Linton, 1969; Myers, 1980; Krueger & Nardine, 1981; VanderVen, 1979). They also frequently encounter practical problems such as coverage or scheduling responsibilities which exclude them from team meetings and limited planning and preparation time which makes it difficult for them to contribute to the meetings they do attend. Thus, unless these and many other problems had been fully overcome, it was conceivable that agencies may not have implemented a team decision-making process.

Conceptual Framework for the Study

The conceptual framework for the study was based on Berman's (1976) prescriptive stage model which represents an organizational process approach to implementation analysis. This approach is grounded in the belief that implementation of a specific policy (team decision-making model) results from the ongoing patterns of mutual adaptation that develop among many "actors" (team members) in

an organization (residential center) and the policy structure. For example, this approach suggests that in order for effective implementation of the team model to occur, team members must be able to change their behavior to accommodate the policy as defined at their center and the policy structure must be flexible enough to accommodate the needs of team members at various stages or phases of implementation.

Berman outlines three stages of implementation: mobilization, deliverer implementation, and institutionalization. These stages serve as guidelines for observing interdependent events that frequently occur in the prescribed sequence. In the mobilization stage, administrators and staff decide to adopt the policy and plan for its execution. Plans are than carried out in the deliverer implementation stage by team members. And in the final stage, the policy is institutionalized as part of the agencies long range operating procedures. According to Berman, effective implementation should occur in each stage; however, because implementation is largely dependent on interactions among staff members, he concludes that studies should pay special attention to the deliverer implementation stage (Berman, 1978; pp. 22-31). For example, concerns about professional status, training and schedules among child care workers would tend to have the greatest impact on the interactions that took place during team meetings or the time when the policy was being "delivered."

With Berman's model, the concerns about child care worker involvement in the decision-making as guideposts, several criteria

for effective implementation were developed (criteria are listed in the following section). These were criteria around which initial questions for the study were framed. The nature of the study, as shall be seen in the following section, also indicated that new questions and criteria would emerge during the course of the study.

The conceptual framework for the study is shown in figure 1 where the three stages are depicted as being interdependent with effective implementation depending on successful resolution of problems in all three stages. As suggested by Berman, the concerns about child care involvement are also shown as having the greatest potential impact on the deliverer implementation stage.

Selection of Sites and Teams

The study was conducted at four residential treatment centers for emotionally disturbed or troubled children and youth. Sites were selected by interviewing state officials responsible for program evaluation and by examining pertinent records and written descriptions of team policies.

The objective was to identify four centers that had a team policy history and an expressed interest in policy implementation.

The final four sites all had at least four teams, with each team having responsibility for six to eight children. Although the composition of teams varied from center to center, all of the teams had at least one social worker, a special education teacher and two or more child care workers. Additional team members included reading and art specialists, clinical consultants, and

administrators.

Two sites were located in rural areas and two in urban areas. Three sites served boys and girls ages 8 to seventeen and the remaining site served older adolescent boys.

Specific teams were selected by asking administrators to identify their "most" and "least" developed teams. The plan was to study two teams at each site that represented the range of team development according to the agencies' own standards.

Procedure

A field study approach, which allowed the researcher to observe team members in their natural settings, was used. Data were collected by observing each of the eight teams in operation at least twice during a two-or three-hour team meeting, interviewing team members and administrators, and examining related documents and records. Notes were taken throughout the study and later analyzed by using a multiple coding system to identify specific classes of information (Schatzman & Strauss, 1976). (See appendix B for interview questions and sample note cards.)

The findings were validated by using three procedures. First, the researcher randomly asked team members to read or listen to a note immediately after it was written and compare the note with their own observations of what was going on at a specific meeting (Buckholdt and Gubrium, 1980). Second, major propositions were validated by host verification: a process in which the researcher called a key department head or administrator and asked if the

finding was accurate according to their perceptions of a specific situation (Schatzman and Strauss, 1973; pp. 133-137). Finally, the findings were validated through conversations with experts in the field including the state program evaluator and the researcher's doctoral advisor.

Implementation Criteria and Findings

According to the aforementioned criteria for effective implementation, which proved to be consistent with each agencies own definition of effective implementation, and Berman's prescriptive tage model, the team decision-making model was only partially implemented at each of the four sites. It is impossible to list all of the findings used to reach this conclusion in this paper; however, it is possible to list the major implementation criteria and to summarize a few of the most pertinent findings in each stage.

Stage One: Mobilization - In this stage the policy is adopted and plans for carrying it out are made.

Criteria:

1. Adoption of the model was consistent with the direction accepted by the child care field, program evaluators and purchasers of service. In the absence of formal mandates there would at least be informal support from the above sources.

2. Formal long-and short-range planning and policy design processes, including meetings and discussions that were open to all staff, occurred and were documented. The assumption according to Berman was that smooth adoption and implementation of a policy are facilitated by a shared planning effort.

3. A consensus decision to adopt the policy was reached among staff members.

4. Agency operating procedures were adjusted to accommodate deliverer implementation. This could include reassignment of staff and children and a change in leadership and departmental structures.

Summary of Mobilization Findings:

While it was obvious that agencies had reorganized by assigning adults and youth to specific teams and that the policy was supported by licensing and referring agencies, the mobilization stage was not characterized by the formal long range decision-making, planning, designing and reallocation of resources which are essential to successful policy adoption. The decision to adopt the policy and plan for its execution was a day-by-day process in which a few key leaders attempted to make implementation decisions that they felt would "eliminate confusion," "increase accountability," and "improve communication." Direct service staff were only marginally involved in the planning process, a formal consensus to adopt the policy was not reached, significant adaptations in operating procedures were not made, and policy designs and long range planning procedures were not recorded. A particularly significant finding in this stage, which also proved to be important in the following stages, was the fact that the leadership structure remained the same throughout implementation and that in general only the occupants of the key leadership positions--social workers and administrators--were present for all three stages. Thus, some changes were made in the mobilization stage at all four sites, but some very significant

changes and planning processes were also overlooked.

Stage Two: Deliverer Implementation - In this stage team members actually carry out or "deliver" the policy.

Criteria:

1. Organizational adjustments are being made to accommodate the team model. The team, as opposed to the department, is the central treatment decision-making body (Garner, 1980). Department heads have equal administrative authority and function as members of an administrative team.

2. Leaders express a verbal commitment to equal professional status for team members and support their commitment with the necessary training and incentives. Staff members exercise their status during team meetings.

3. Working schedules are adjusted to allow team members to attend and participate in team meetings or at least give members an equal opportunity to attend and participate. Team members attend and participate.

4. Consensus decision-making is the predominant method of treatment decision-making.

Summary of Deliverer Implementation Findings:

The deliverer implementation stage can best be described as a paradoxical situation. On the one hand, administrators and team members voiced extreme confidence in the current system. Most of them felt that the "team was the only way to go" and that it was much better than the previous system. Yet, it was obvious while conducting interviews, observing at team meetings and examining

records that team members and centers were still struggling with many of the major problems that had interfered with decision-making prior to team adoption. Once again, changes had been made, but there were many equally vital structural changes and changes in staff behavior that had not been made.

Since this stage received the most attention in the study, the findings are divided into four major subheadings: organizational adjustments, professional status, schedule adjustments, and decision-making.

Organizational Adjustments - With the exception of one site, the adjustments in organizational hiearchy and structure needed to accommodate the model had not been made. At the department head level, social work continued to enjoy more authority than education and child care. Social workers were also designated as team leaders or "facilitators" on all eight teams. And, while it can be argued that "someone has to have final authority," concentrating this authority among members of one profession did little to enhance the overall sense of team equality. For example, in controversial situations, child care workers often gave up or deferred to social workers because they felt that they would make the final decision anyway.

The agencies had also been unable to obtain a successful marriage between departments and teams. Team members often came to team meetings with "one foot in their department" and the other in the team (Garner, 1980 p. 2). This struggle was particularly

evident in discussions around key isues such as "behavior management," "intake policies," and "coverage." In other words, team members often put more energy into advocating their department's position on these issues than trying to reach an agreement about what was best for an individual child.

Professional Status - Everyone interviewed, except one specialist, felt that child care workers should have at least equal, if not greater, status than their fellow team members. Statements such as "our child care workers are the most important team members," were not uncommon. At the same time, however, there was an absence of programs and incentives that would indicate that child care workers were indeed worthy of equal status. For example, incentives such as salaries, opportunities for advancement to leadership positions, and fringe benefits were still considerably lower for child care workers than other team members. Child care workers and administrators alike also agreed that training and supervision in teamwork and communication were definitely inadequate. Concommitantly, the supervision and training that were available were generally provided by members of the other disciplines and rarely from within. It was not surprising then that workers in general were less influential than social workers and teachers. The results are perhaps depicted best by two comments. The first came from a social worker who stated that he felt little resistance from team members because he could usually "manipulate them to go alone with him." The second comment came from a child care worker who was certain that she knew more about the children

than her fellow team members but "didn't know how to express herself when she got to team meetings."

Schedule Adjustments - With the exception of one site, child care workers were not scheduled to attend an equal number of team meetings as social workers and teachers. At one center only one child care worker was scheduled to attend key team meetings (consultations) while the other workers on the team were either scheduled off duty or covering the unit. In general, workers were scheduled to attend about half of the meetings with the option to come in on their time off if they so desired.

At three centers the time allowed for team meetings was not adequate to cover the amount of information that needed to be processed. Team members were often forced to pass over very important decisions because there was not enough "time to cover everything."

Decision-Making - Decisions were generally made very quickly. Informal procedures such as having the team leader look for nods of appoval, eye contact, or a slight verbal response were the normal course of action. With particularly controversial issues team members did on occasion ask for a vote, but the usual procedure consisted of a brief conversation among a few team members who could make the decision and then seek informal approval from the rest. On several occasions the researcher felt that a consensus had not been reached, even though it appeared that a decision was made. This was later verified by comments such as "it doesn't make any difference; we just go back to our unit and do our own thing."

Areas of decision-making responsibility were also unclear. For example, in one instance the team was asked to make an intake decision which was later overturned by the administrative staff. This caused one team member to comment, "I don't know why they ask us to make the decision when they are really the ones who will decide."

Stage Three: Institutionalization - In this stage practices are institutionalized as part of the agencies' operating procedures.

Criteria:

1. Written treatment plans reflect team input.
2. Written program summaries indicate that treatment plans are being carried out according to team decisions.
3. Team functions are included in job descriptions for all team members.
4. The center's written decription of teams and team philosophy is updated.
5. State evaluators and purchasers of service would indicate awareness and acceptance of the center's team approach.

Summary of Institutionalization Findings:

It appeared on the surface as if most of the agencies had institutionalized the team model, at least according to the criteria for effective institutionalization. They all had written planning and evaluation systems with sections for contributions from each discipline, job descriptions which included team functions, written descriptions of team philosophy, and support from external agencies for using teams. Written descriptions of the team policy and its operations were not, however, always reflective of what was actually

occurring in practice. Instead, reports and documents often appeared more reflective of leader's and team members' ideal definitions of implementation than actual implementation. For example, job descriptions outlined team decision-making functions, but schedules often made it impossible to carry these tasks out. Recording and observing procedures referred to team participation, but at two sites leaders weren't sure that workers knew how to use the procedures and at another site workers saw these procedures as being obstacles, rather than aids, for decision-making.

A Unitary Analysis

A unitary analysis was used to answer questions about implementation shortcomings. This perspective suggests that implementation problems result from key leaders' inability to rationally assess a problem, establish alternative courses of action and estimate the consequences that flow from each action (Allision, 1969; Havelock, 1969; Peterson, 1976). In this context, implementation problems were interpreted as being symptomatic of the failure of leaders to make the decisions that would allow for the mutual adaptations prescribed by Berman. In other words, without decisions to enhance the opportunity for equal status, to change organizational structures and hierarchies, and to develop policy statements and long range plans team members could not sufficiently change their behavior to accommodate the policy.

This analytical perspective had particular relevance to these residential centers because a few key leaders were the only members

of the organizations who had survived the evolution of existing models. With only one or two exceptions, the agency director and one, two or three social workers were the only individuals present throughout the stages of implementation. Thus, they were largely responsible for making the decisions related to the model's development. Had other team members been present for similar amounts of time, shared in making policy decisions, and had sufficient experience in team decision-making it might have been concluded that their failure to make mutual adaptations with the policy was largely responsible for the state of the team model. But this was not the case and without more supportive or decisive decisions from leaders, even if this meant involving team members in a remobilization process, team members could not be expected to make the necessary adaptations.

This position was supported by three further arguments. First, leaders did have alternative choices with greater probabilities for success. Precedence had been set in areas such as policy design (Cibulka, 1978), organizational adjustments (Garner, 1980), training, incentives, supervision, and scheduling. Second, leaders experienced role conflicts and dilemmas that were identified as hindrances to decision-making (Issak, 1975). Social pressures to be accountable, to follow traditional procedures and to protect professional identity were formidable obstacles in attempts to initiate change (Marris and Rein, 1973). They were also subject to feelings of insecurity and loss that accompany attempts to decentralize treatment decision-making.

Finally, leaders were able to "mobilize bias" among staff to accept their indecisiveness and non-decisions (Bacharach & Baratz, 1970). In other words, when leaders explained that their "hands were tied by outside forces," or "that everything possible was being done," staff members either accepted their reasons or they lacked the collective bargaining ability to persuade leaders to pursue alternatives.

Leaders did not intentionally subvert further implementation. They were indeed hampered by dilemmas, feelings and perceived restrictions from outside sources. They were also unaware of recent studies in the organizational and child care fields which may have alleviated some of their ambivalence. Thus, in the final analysis the researcher felt that leaders were committed to further implementation and that with the proper support and awareness they would be willing to move to a point where staff members could make the mutual adaptations prescribed by Berman.

Recommendations

The following recommendations were based on the findings from the study and organized according to Berman's three-stage model. Precedence for each recommendation had been set in other centers or in similar organizations.

1. Remobilization

An attempt can be made to remobilize by involving staff members in a consensus decision-making process to adopt the current team policy or a revised form of the policy. This process can include staff planning meetings, needs assessments, interviews, and

surveys. The purpose is for leaders to get as many staff members as possible involved in adopting, adapting and accepting the team model.

2. Policy Design and Strategy

A clearly designed policy statement and long range plans for implementation should be major outcomes of remobilization. Statements and strategies should be described in an easy to follow written document. An evaluation system which is manageable for all staff members should also be developed to monitor progress (Staff input is also essential in designing the evaluation system.)

3. External Support

Leaders can make an attempt to involve state and local officials in the remobilization process. Particular emphasis should be placed on identifying restrictions and areas of support. Implementation will flow more smoothly if both internal and external parameters and support systems are clearly defined from the beginning.

4. Leadership and Departmental Reorganization

Leaders can consider abandoning the departmentalized system in which staff are required to be members of teams as well as departments in favor of total team approach (Garner, 1980). In this approach teams assume responsibility for treatment and administrative decisions related to the team, and leaders assume administrative roles formally performed by department heads. If this is not possible, each department head should at least have equal authority in the organizational hierarchy and a department head team decision-making process should be used to resolve departmental differences. The objective is to minimize the impact that departmental differences have on team treatment decision-making.

Team leadership can also be evenly distributed among disciplines. If child care workers or teachers with leadership capabilities are not available, then a system can be put into effect to prepare them for future openings. This preparation, of course, will have to include appropriate work incentives and training.

5. Levels of Decision-Making

Leaders can clearly define policy, allocation and coordination decision-making parameters (Parsons, 1960). All of the members of the organization need a clear understanding of decisions they can make, decisions they can't make and how decisions interface with each other. It is understandable that there will always be some disagreement, but without decisive action to clarify areas of decision-making and to explain reasons for the way authority is allocated, team members will remain needlessly confused.

This process can be helped by staff and team discussions during the establishment of various decision-making areas, and continuous open communication after the determinations have been made. For example, if leaders are responsible for final policy decisions regarding the intake of children, confusion and resistance can be avoided if leaders clearly explain the rationale for a policy change before a team is involved in an intake decision.

6. Training

Ongoing training in communication, teamwork, observing and reporting, team philosophy, conflict resolution and assertiveness are essential for effective deliverer implementation. Leaders can

find examples of effective training programs by referring to the adult education and child care literature (Beker, 1980; Krueger, 1981; Porter, VanderVen & Mattingly, 1980). Leaders can also make a more concerted effort to hire child care workers with related academic training. Potential candidates can be recruited from child caring programs and related human service programs at a number of colleges and universities throughout the United States.

7. Incentives

Agencies and leaders can be more innovative and creative in finding ways to increase incentives for child care workers. For example, step plans or career ladders which are based on projected savings from reduced turnover and increased effectiveness can be initiated. Support for this approach can be found in the child care and organizational literature (Krueger, 1981; Mattingly & VanderVen, 1981).

8. Schedules

Teams can't operate effectively without an equal opportunity for all team members to attend decision-making meetings. If the cost of paying for everyone to come to meetings or the need for coverage are prohibitive, then reciprocal arrangements can be worked out among all the departments. This will at least give everyone an opportunity to spend the same amount of time at meetings. Meetings should also be scheduled on a weekly basis with enough time provided to cover the child or children scheduled for that meeting and to address team members' concerns.

9. Decisions

A formal process for reaching consensus can be developed to avoid unsupported decisions. Each team member needs an opportunity to formally participte in each major decision and to reach a compromise on those issues he or she disagrees with.

10. Reinstitutionalization

Team philosophy statements, team structures, job descriptions and evaluaton procedures can be revised to reflect actual implementation. This process will be enhanced by involving staff in making suggestions and necessary revisions.

Summary

The findings and recommendations from this study can help leaders reach a point in implementation where staff members will be better able to adapt to the policy. Whether or not further implementation and desired outcomes will be achieved are questions which will have to be answered in future studies.

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APPENDIX A

Interviews, Record Examination, Notes, and Data Analysis

Interviews

Semi-structured interviews were conducted with agency directors and all team members. The ten general questions listed below were asked of each interviewee with encouragement given to expand upon their answers and offer any additional information they felt needed to be shared. Techniques such as "hypothetical questioning," "posing the ideal," and "offering alternatives or interpretations" were used, when appropriate, to

present the questions(Schatzman and Strauss, 1973). Notes were taken throughout the interview. Samples of questions follow:

1. Please describe the team model as you see it, ideally.
2. How did the team model get started?
3. Were you involved in the planning? Or, who was involved in the planning?
4. If you had it your way would you use the team model?
5. What kinds of compromises have you had to make as a team member?
6. How often do you get to attend team meetings?
7. When a team is working well all the members are able to make significant contributions. Do you think this happens very often?
8. Do other team members usually listen to what you have to say?
9. Sometimes team members feel dominated by other team members. How do you feel about your own involvement? Are you passive or assertive?
10. Has your training to be a team member been adequate or inadequate.

Record Examination

The following records were examined at each center:

1. Personnel Practices

2. Job Descriptions
3. Working and Meeting Schedules
4. Written histories and descriptions of teams. (Whenever available)
5. Treatment plans and programs
6. Promotional systems
7. Organizational charts
8. Training Schedules

The purpose for records examinations was to seek out information that might either support or conflict with team implementation as described in the initial study design and to uncover new variables which might be of significance to the study. Notes were taken during examinations and whenever possible, copies of records were obtain for filing with the study.

Notes

Copious notes were taken on yellow legal pads throughout all phases of the study. These were labeled according to three categories: observational notes, theoretical notes and methodological notes, (Schatzman & Strauss, 1973). Observational notes were statements bearing upon events experienced principally through watching and listening. For example, the following observational note was taken at Site A:

The social worker and team supervisor begin the meeting with

an informal discussion of potential intakes. Then the social worker hands out a team effectiveness rating scale and explains its purpose to the team members. The other team members indicate they are familiar with the process and begin to fill out the scale.

Theoretical notes represent a self-conscious controlled attempt to derive meaning from one or more observational notes. The following theoretical note was taken at Site B:

Up to this point the child care workers have been making many treatment decisions regarding the disciplining of group members. However, one might question these decisions as being extremely punitive and without a direct connection to specific treatment plans. The absence of supervisory leadership and outside objectivity is apparent.

Methodological notes represent an operational act completed or planned: an instruction to oneself, a critique of ones own tactics. The following note was taken at Site C:

Remember to review the organizational chart to check the senior child care workers administrative authority.

After each meeting, interview and examination notes were reviewed and if necessary rewritten. Caution was also taken to make sure that notes were correctly labeled and key events not omitted.

Data Analysis

Once the visits to a site were complete, notes were transferred to manual keysort note cards and coded. The coding system consisted of using numbers to identify code words that stood for twenty-two specific areas of interest or concern. Areas were identified by selecting topics from the original

design and by identifying topics that emerged throughout the course of the study. For example, a design topic area was labeled "professionalism" and a new topic was called "experience." Each note card was then punched in the appropriate number slots. Cards could be identified by one or several code words. The coding system is listed below. A sample note card is depicted in Figure 2.2.

Code for Note Cards

1. Mobilization
2. Deliverer Implementation
3. Institutionalization
4. Professionalism
5. Organization and Administration
6. Training
7. Scheduling
8. Incentives
9. Leadership
10. Supervision
11. Assertiveness
12. Experience
13. Unresolved Issues
14. Consistency
15. Communication
16. Trust

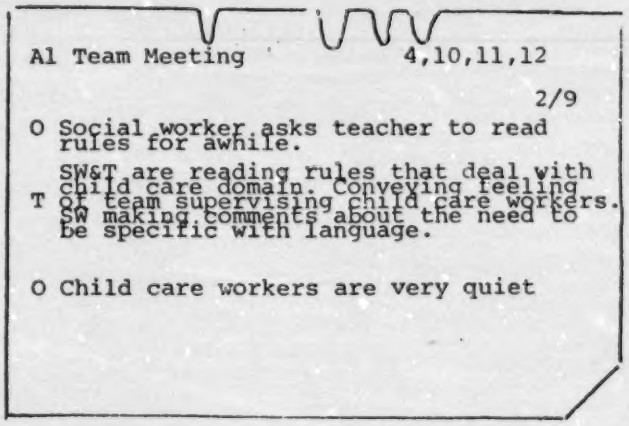
Al Team Meeting 4,10,11,12
2/9
O Social worker asks teacher to read rules for awhile.
T SW&T are reading rules that deal with child care domain. Conveying feeling of team supervising child care workers. SW making comments about the need to be specific with language.
O Child care workers are very quiet

Figure 2.2 Note Card